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ABSTRACT

Exploring health needs of rural America, the paper concludes that the 2 most basic problems of rural areas are medical manpower and organization of services: the most acute needs are for more primary physicians and for better organization of primary medical practice. Of the various methods considered for geographical redistribution of medical manpower to rural areas, the one that may hold the greatest promise is the recruitment of physicians to organized groups. Also, in some rural areas, solutions completely different from the traditional "physician in residence" must be sought. Emphasis may be needed on expanded transportation and communication capabilities, part-time use of physicians and allied health workers, new physician support occupations, and better understanding of individual health practices. To help close these gaps in rural communities, several suggestions are offered, such as: (1) physicians in communities can lead recruitment efforts; (2) if communities do not have adequate financial and population resources for recruitment, they can combine their resources with nearby communities; (3) citizens in every community can make efforts to reduce the burdens they place on rural physicians; and (4) the need for medical personnel can be advertised through physician placement services, medical schools, and teaching hospitals. It is also noted that, to improve rural health, the totality of deficiencies in rural living today must be addressed. (KM)

PHYSICIANS FOR RURAL COMMUNITIES*

The two most basic health care problems of rural areas are medical manpower and organization of services; the most acute needs are for more primary physicians and for better organization of primary medical practice. Solving either of these would aid in accomplishing solution of the other. Adequate manpower enables the task of organization to go further than it otherwise could, and group organization of practice can make recruitment and retention of physician manpower easier to accomplish. Of the various methods considered for geographical redistribution of medical manpower to rural areas, the one that may hold the greatest promise is recruitment of physicians to organized groups.

An explanation of the factors responsible for the maldistribution of physicians requires consideration of a variety of complex elements -- socio-economic conditions, physical barriers, demographic factors, geographic location of the county, the way medicine is practiced today, and locational preferences of individual physicians.

What does "maldistribution" of physicians really mean? According to the "ideal" physician population ratios developed by specialty leaders in 1972 and stated as approximate mid-range figures, the threshold population required to support a family physician was 2,000, for a general surgeon 10,000, for a urologist 30,000 and a neurosurgeon 100,000.

Perhaps we should insert an optimistic note here for a rural state like Nebraska. In New York, the state with the highest ratio of physicians to patients (196 per 100,000), life expectancy is nearly 2.5 years less than in Nebraska where the ratio is 100 physicians to 100,000 patients.

Good health depends not only on physicians but upon heredity, socio-cultural and environmental factors like the pace of living, diet, air pollution, etc. These factors obviously account for the higher life expectancy of Nebraska people as compared to citizens who live in large urban metropolitan centers.

HEALTH CARE SYSTEMS

It is certain that many small communities that once had their "own" physician will never again have one of their own. It has become clear that, for some rural areas, solutions completely different from the traditional "physician in residence" must be sought. In such areas, emphasis may be needed on expanded transportation and communication capabilities, part-time use of physicians and allied health workers, improved bio-monitoring technology, use of new physician support occupations, better understanding of individual health practices, and development of emergency care and self-help methods to ensure rural health coverage.

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* Presented by Bond L. Bible, PhD, Director, AMA Department of Rural Health, for the Rural Sociology Section, Association of Southern Agricultural Scientists Annual Meeting, Memphis, February 3-6, 1974.

Basic to the development of rural health systems is the initial planning by rural communities. It must be regional in scope, based on economic service areas. It must involve all segments of the community, provider and consumer alike, with support of planning agencies and government at the county, state, and federal levels. It must be elastic and tailored to the geography and the potential resources of the locality. Hopefully, the plans will always provide a "one door" service for all economic levels rather than serving the middle class or becoming an indigent clinic serving only the poor.

Multiple communities in a logical service areas will need to plan together to develop health care systems on an area basis to attract appropriate health manpower working in a group to provide home, clinic, and hospital care. Planning for health services on an area basis makes it necessary to think in terms of time rather than distance. Planning must also recognize divergent needs for services requiring new types of health workers, technology, and emergency care practices.

We must emphasize that there is no one, simplistic solution applicable to all medically deprived rural locales; rather, each area will need to develop its own plan, incorporating those approaches most appropriate to their particular needs. Of prime importance is coordination of planning. There is an urgent need for system development with physician and hospital linkages.

In applying the community systems approach to the delivery of health services, a real problem of concern is seen to be not simply health care or medical organization within the community, but rather community organization for health care in the context of the total community with all its objectives and problems.

Educating community leaders to the potential of rural development, including planning for readily available and accessible health services, can play a significant part in improving the quality of country living. To support such an educational approach, the Council on Rural Health cooperates with the U.S. Department of Agriculture in an effort to encourage direct communication and participation between state medical association rural health committees and their respective state USDA rural development committees. The response to the Council's communication with the state USDA rural development committees has been gratifying. Most of the state RD committees are contacting and seeking guidance from the physician chairmen of the rural health committees. They are anxious to involve physicians and others concerned with health care in the RD program.

RECRUITMENT STRATEGIES

Analyses of physician distribution reveals a direct correlation between the physician-to-population ratio, per capita incomes, community size, and medical facilities.

Several trends explain the increasing concentration of physicians around medical centers and hospitals. The increased complexity of modern medical technology has caused the cost of equipment and personnel to operate it to rise so high that an individual physician cannot generate sufficient demand to justify its purchase --therefore, the physician is dependent upon public and private investment in equipment and personnel. Second, the increasing specialization of physicians

requires even more expensive equipment and increases their dependence upon hospitals and other physicians for diagnostic and curative referrals.

The growth and development of family practice programs in medical schools is noteworthy. For example, 59 new family practice residency programs were approved during the past year, bringing the total to 164. The number of family practice residents has increased from 104 in 1969 to 1,771 during 1973. A number of state legislatures, particularly those states with a considerable rural populace, are increasing financial support for family practice programs in their medical schools. Emphasis and focus on family practice programs at its National Conferences on Rural Health continues to be a prime objective of the Council on Rural Health. With programs that increase the number of family practitioners, it would increase the pool of physicians available for possible rural practice locations.

Among the corrective methods that could be utilized in alleviating this imbalance is the attempt to attract medical students, who, due to their background and motivation, are most likely to select rural locales for their practice. A number of studies indicate that physicians practicing in small towns are more likely to have a rural than urban background. A study of recent medical school graduates shows that a physician's background is a major influence in his choice of a practice location. Specifically, the survey reveals that rural-reared physicians were three times as likely to choose rural practice as urban reared respondents. Some state medical associations have considered or acted on the proposal to try to identify students most likely to locate in rural areas. For example, the Utah House of Delegates adopted a resolution to request the University of Utah College of Medicine to form a special committee to develop criteria for identification of such students. Thus, a program that would increase the number of medical school graduates having a rural background should be advantageous since it would increase the pool of physicians most likely to select rural practice locations.

Planned exposure of medical students to rural practice and life style has been a continuing effort of several medical schools. Fifty family medicine programs now exist in medical schools providing clerkships or preceptorships for family medicine in a community setting. The preceptor, preferably in a group practice, must be carefully selected. Several promising demonstration projects are underway such as the one in Maine which involves arranging clinical field experiences in rural areas under university staff supervision for teams of health students from colleges and universities in Maine and other New England States. Much greater effort and expenditure of resources is needed in this phase of medical education.

Direct medical school involvement with local communities and their problems is another promising development. This move toward a regional concept of rural health care delivery with rural-urban linkages is successful in several small communities. Decentralized medical education is exemplified in exploratory programs such as the Illinois Plan, the Minnesota Physician Associate Plan, SAMA student projects, and Area Health Education Centers linking health service organizations and educational institutions serving students, practitioners, and communities.

The importance of partnership or group practice opportunities, however, should not be minimized. Availability of a suitable group practice opportunity is important in attracting a physician, and in retaining him. This future trend should lead individual physicians, medical societies, and community leaders to support the initiation of partnership or group practices in needy rural areas and to extend existing group arrangements.

All physicians are aware of the need for continuing medical education because of the enormous growth of a new scientific knowledge. Rural physicians are deeply concerned about opportunities for professional growth and access to continuing medical education programs. Physicians in isolated rural communities are concerned, because of limited opportunities to participate in these programs.

Some medical schools have developed educational programs extending into the communities. Such programs are urgently needed and can be coupled with student, intern, and resident teaching assignments within the communities. This accomplishes the multiple purpose of education in realistic community environments; stimulation and education of the local practicing physician and attracting young physicians to select such communities for their future practice sites. Many state medical associations have developed programs of accreditation to survey community hospitals and other local institutions helping them to build good quality continuing medical education programs at the local level.

The Council on Rural Health believes the AMA should explore the possibility of designing and implementing a physician exchange program. Under the program a rural physician and his family could "trade places" with his urban counterpart for a short period of time. A demonstration program should be developed. It should provide reimbursement for relocation expenses and incorporate continuing education seminars and rounds at urban medical centers. This would provide rural physicians opportunities to revitalize their social and professional perspectives, enhancing the potential for expansion of rural-urban interrelationships. Urban physicians would gain exposure to a different practice and life style. Some may elect to practice in rural locales permanently.

Many rural communities now seeking physicians have, individually, too small a population to support a physician and necessary support personnel and resources. Such rural communities in a logical health service areas should plan together and develop health care systems on a regional basis. With a broader base of population and resources the region could attract and support the needed physicians, allied health professionals, and other resources.

Physician recruitment in rural America could be aided by a central clearing house. Conceptually, this office would obtain and coordinate background information and interests for selected interns, residents, and other physicians, as well as data on regions interested in recruiting physicians. Physicians and regions could then be matched based on areas of common value. The AMA Physicians' Placement Service anticipates expansion through computerization providing the capability for assisting in such a referral service.

CLOSING THE GAPS

The search for rural health manpower must generally be geared to an area-wide health care system. Nowhere can this be done better than in the small towns with which are most concerned. They can identify their own nurses, active or retired, technicians, teachers who have health skills, or others who can be trained to perform relatively simple, but nonetheless critical, services. A nurse with special training or other specifically trained assistants can relieve the physician of many time-consuming professional activities and allow him to use his professional skills much more productively. The focus in these endeavors is on community consciousness. The greatest investments will be in deliberate planning based on a belief in the rights of all citizens to have access to good health care. With modest expenditure, small communities can establish efficient emergency care through the use of everything from a pool of private automobiles to well-equpped ambulances or (with greater expense) helicopters.

We suggest several ways to help close the gaps in providing physicians for rural communities.

1. There is need to place continued and increased emphasis on family practice programs in medical schools.

2. The development of quality family practice residency programs must have much greater state and federal support.

3. Support and assistance should be given to programs that would increase the number of medical school graduates who have a rural background.

4. Establishment of group practice is one potential means of attracting physicians to rural communities. Availability of a suitable group practice opportunity is not only important in attracting a physician, but it is apparently important in retaining him.

5. Resources must be sought to develop and implement comprehensive continuing medical education programs for rural physicians.

6. Physician recruitment in rural America could be aided by a central clearing house. Conceptually, this could involve obtaining profiles for selected interns, residents, and other physicians desiring to select a new practice site, while at the same time obtaining profiles for recruiting regions. Physicians and regions could then be matched based on certain areas of common values.

The AMA Physician's Placement Service is anticipating expansion through computerization in its data-processing capability and this would provide the capability to assist such a matching process.

7. Multiple rural communities in a logical health service area should plan together and develop health care systems on a regional basis. With a broader base of population and resources, the region could attract and be able to support the needed physicians, allied health professionals, and other resources.

   As a vehicle to help implement the development of rural health care systems, an AMA proposal to improve rural health was introduced in both houses of Congress on October 1. The bill calls for creation of an HEW Office of Rural Health through which grants contracts, loans and loan guarantees could be made to assist in the development and demonstration of rural health delivery models and to study existing models. A Rural Health Care Advisory Committee would be established.

8. Education for rural health is a fundamental aspect of community health services and is basic to every health program. Given the present demand in health care, a major effort directed at consumer health education should receive high priority. This is particularly essential in rural areas where health manpower is most limited. The greatest untapped manpower resource in this country is the individual consumer. Needed is an informed and "activated" citizen who can take his own initiative in personal health management program.

9. There is need to develop pilot programs for primary care medical school staff and rural physicians to have periodic visitations for professional improvement and assistance.

   We reiterate that rural physician recruitment has proven to be very difficult.

To summarize, several suggestions are: 1) for the physicians in the community to lead the recruitment effort (if no physician practices in the community, several outstanding citizens should assume this role); 2) if the community does not have the financial and population resources for successful recruitment, they should combine their resources with a nearby community; 3) the citizens in the community should make every effort to reduce the burdens they place upon the rural physicians; 4) make an inventory of the health needs and community resources; 5) prepare a fact sheet about the area; and 6) contact physician placement services, medical schools, teaching hospitals and advertise the needs for medical personnel.

One thing is clear from our past experiences in developing models for health care services. Behind all success is generally one man -- usually a physician or a small group of men -- a medical society or hospital board -- that have the creative intelligence -- the vision to see what can be -- and the strength to make it happen.

All of us must recognize that "health" does not exist in a vacuum. Health is but one aspect of the "quality of Life" which includes all the socio-economic, ecological, and educational factors which make for a satisfactory living situation. To improve rural health we must also address the totality of deficiencies in rural living today.

It seems to us that there is still time, indeed we must still have time to experiment in the development for models for rural health care. This country is so diverse geographically, economically, culturally, that to be locked into one rigid system would be self defeating. We still need to learn how rural - urban health system relationships can best be developed. We need to recognize the uniqueness of communities and give them frameworks in which their uniqueness can best be served. This can be done only by total involvement of all segments of the community in developing appropriate health service systems.